Print Form

State of California – California Health and Human Services Agency
Office of Statewide Health Planning and Development

CALIFORNIA CABG OUTCOMES REPORTING PROGRAM
Extension Request Form

PHONE (916) 326-3865
FAX (916) 445-7534

OSH-CCORP 418 (Revised 06/17)

Extension Request Form

Hospital Name:

Facility ID:

Date:

Report Period: Begin Date: End Date:

Number of Days of Extension Request:

Extension request submitted by:

Name and Title (Please print)

Phone Number: Fax Number:

Signature:

OSHPD USE ONLY

Extension Request (circle one): Granted Denied

By: **Date of CORC System Input:**